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RESEARCH ARTICLE



The existential dimension in general practice: identifying understandings and experiences of general practitioners in Denmark

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ABSTRACT

Objective: The objective of this study is to identify points of agreement and disagreements among general practitioners (GPs) in Denmark concerning how the existential dimension is understood, and when and how it is integrated in the GP–patient encounter.

Design: A qualitative methodology with semi-structured focus group interviews was employed.

Setting: General practice setting in Denmark.

Subjects: Thirty-one GPs from two Danish regions between 38 and 68 years of age participated in seven focus group interviews.

Results: Although understood to involve broad life conditions such as present and future being and identity, connectedness to a society and to other people, the existential dimension was primarily reported integrated in connection with life-threatening diseases and death. Furthermore, integration of the existential dimension was characterized as unsystematic and intuitive. Communication about religious or spiritual questions was mostly avoided by GPs due to shyness and perceived lack of expertise. GPs also reported infrequent referrals of patients to chaplains.

Conclusion: GPs integrate issues related to the existential dimension in implicit and non-standardized ways and are hindered by cultural barriers. As a way to enhance a practice culture in which GPs pay more explicit attention to the patients' multidimensional concerns, opportunities for professional development could be offered (courses or seminars) that focus on mutual sharing of existential reflections, ideas and communication competencies.

KEY POINTS

- Although integration of the existential dimension is recommended for patient care in general practice, little is known about GPs' understanding and integration of this dimension in the GP–patient encounter.
- The existential dimension is understood to involve broad and universal life conditions having no explicit reference to spiritual or religious aspects.
- The integration of the existential dimension is delimited to patient cases where life-threatening diseases, life crises and unexplainable patient symptoms occur. Integration of the existential dimension happens in unsystematic and intuitive ways.
- Cultural barriers such as shyness and lack of existential self-awareness seem to hinder GPs in communicating about issues related to the existential dimension. Educational initiatives might be needed in order to lessen barriers and enhance a more natural integration of communication about existential issues.

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Introduction

The specialty of general practice defines itself as devoted to a holistic, patient-centered care.[1] Apart from attention to physical, psychological, social, and

cultural dimensions in dealing with health problems, integration of the existential dimension is described as clinically relevant and as a professional and ethical responsibility of general practitioners.[2,3]

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However, while the existential dimension in general practice has received an increased normative focus in the past couple of decades, very little attention has been paid to how GPs understand the existential dimension, and to when and how it is integrated into the encounter with the patient.

While no explicit definition of the existential dimension seems to exist in documents and policies pertaining to general practice, the palliative care literature refers to different understandings that include issues related to identity, personal integrity, or an unfulfilled past, as well as issues relating to future concerns such as meaninglessness, hopelessness, death, futility, and spiritual/religious concerns.[4]

Clarifying understandings of the existential dimension as it applies to general practice is an important endeavor given that different concepts have been used interchangeably within a general practice research context to cover parts of the same empirical reality. Thus, a large body of empirical studies emanating from the USA and European countries employ the broad and seemingly ubiquitous concept of “spirituality” and “spiritual care”.[5,6] “Spirituality” – as understood within a “spiritual care” framework – is mostly understood as encompassing the existential dimension, without being the same, and is furthermore regarded as synonymous with “the existential” and/or with “religiosity” sharing the realms of meaning/purpose, belonging/connectedness/love/relatedness, and the sacred or significant.[7] This complex, conceptual landscape, in which concepts are not uniformly nor consistently employed, makes it natural to assume that GPs may understand the existential dimension and its possible relationships to spirituality and religiosity in multiple ways.

GPs’ understanding of the existential dimension is likely to be shaped by the context and culture in which they are embedded. Thus, it is natural to assume that GPs within a secular, European setting are primarily concerned with secular existential orientations, such as meaning, the value of life, personal values, freedom, responsibility, and loneliness, that are not centered in spiritual and religious worldviews and values.[8] Furthermore, it is likely to assume that the understanding of what is meant by the existential dimension is likely to shape *when* GPs address the existential dimension, and *how* they address it in the encounter with the patient – which ultimately affects the types of care that GPs provide to their patients.

Thus, the aim of this study was to identify points of agreement and disagreements among GPs in Denmark concerning how the existential dimension is understood, and when and how it is integrated in general practice.

The study attempted to answer the following research questions:

How do GPs understand the existential dimension?

When is the existential dimension addressed in the GP–patient encounter?

How is the existential dimension addressed in the GP–patient encounter?

Material and methods

This study forms part of a larger mixed-methods research study in Denmark aiming at developing and evaluating an intervention that targets GPs and that focuses on qualifying the GP–patient communication about issues and concerns related to the existential dimension.

The methodological approach employed in this study was rooted in a qualitative description inspired by a hermeneutic-phenomenological research methodology.[9] The influence from a hermeneutic-phenomenological methodology was reflected in (a) the explorative focus of the research questions on GPs’ understandings and lived experiences of the existential dimension as a phenomenon and in (b) the hermeneutic attempt to understand the data beyond the immediate claims of the individuals, albeit without producing any high-inference, theoretical interpretations of the data.[10] As a method for data generation, focus group interviews were chosen since the members of a focus group respond directly to each other, generating a dynamic exchange of understandings, experiences, and vocabulary related to the topic at hand while a moderator probes for further explanations.[11]

GPs from two of the five regions in Denmark (The Central Denmark Region and The Southern Denmark Region) with a certified speciality in Family Medicine and a minimum of 3 years of experience as practicing GPs were invited to participate in a focus group interview. Research colleagues being practicing GPs themselves and not involved in the study helped identify participants by providing e-mail addresses to 30 primary care clinics and to four practice-based small groups (the so-called “Tolvmandsforeninger”). From that sample of participants, we attempted to achieve variation with respect to age, gender, practice type, practice experience, and practice location (rural or urban area). The final sample consisted of 31 GPs (17 males and 14 females) between 36 and 68 years of age (Table 1). All participants gave their written informed consent, and once ethical approval was received from the *Danish Data Protection* (J. no.: 2015-41-3859), data generation commenced.

Table 1. Demographic data of the participating GPs.

	N (%)
Male	17 (54.8)
Female	14 (45.2)
Location of GP practice	
Rural	19 (61.3)
Urban	12 (38.7)
Type of GP practice	
Single	6 (19.4)
Group (two or more GPs)	25 (80.6)
	Mean age (range)
Male	54 (36–68)
Female	49 (38–68)
Years of practice experience	18 (3–42)

Table 2. Interview guide for the focus group interviews.

Main themes	Probing questions
General understanding of the existential dimension – how?	<ul style="list-style-type: none"> • Could you please describe to me how you understand the existential dimension in general – without necessarily linking it to a general practice setting?
Specific understanding – when?	<ul style="list-style-type: none"> • Could you please tell me when you have experienced to meet the existential dimension in your daily practice? • When is the existential dimension expressed by your patients, according to you?
Specific understanding – how?	<ul style="list-style-type: none"> • How do you address the existential dimension in the encounter with the patient – if at all? • Have you experienced to refer one of your patients to a psychologist, a chaplain or other religious specialist? • How do you address more spiritual or religious issues with the patient – if at all?

Seven focus groups (with 3–6 participants per group) were held between April and September 2015 in the office of one of the group participants. The first author, a sociologist of religion and an experienced qualitative researcher, moderated five groups, and the last author, a theologian having long-time experience with qualitative research moderated two focus groups. We followed a semi-structured interview guide (Table 2). To facilitate a gradual disclosure of the GPs' understandings and experiences as they related to the existential dimension, the guide began with an open request to describe what the GPs understood by the existential dimension in general. The remaining questions explored the existential dimension as it applied to a clinical practice setting.

The recruitment of new groups continued until an exhaustion of the topics included in the interview guide was achieved. The discussions were audiotaped and transcribed verbatim, and lasted from 1 h to 75 min.

Data analysis

Data were analyzed according to the core principles of a thematic analysis approach.[12] The first and last authors (E. A. H. and N. C. H.) performed the analysis. In addition, the analytic process (including coding and interpretation of the texts) was presented to and discussed with the other members of the author group. Interview transcripts were read in their entirety several times in order to gain a general understanding of the data. The text was divided into meaning units that were grounded in the particularity of what was being said by the participants.[13] The subsequent stage of analysis aimed at transforming meaning units into themes with special attention to how they related to the three main research questions. As the clustering of themes emerged, they were repeatedly checked against data to ensure their grounding in the empirical material. A table with research questions (key themes) and sub-themes was generated with associated data sequences. The table was discussed between E. A. H. and N. C. H. including deviations and counter-examples, group dynamics, such as emergence of dominant voices, the deferring to the opinions of others, and evolving consensus.[14] In the following, the three key themes are presented with exemplary data sequences: (1) GPs' understanding of the existential dimension, (2) circumstances under which the existential dimension is addressed in the GP–patient encounter, and (3) How the existential dimension is addressed in the GP–patient encounter.

Results

GPs' understanding of the existential dimension

Except from one female GP showing direct reluctance to describe the concept and stating difficulties of apprehension, all GPs attempted to describe and discuss among them the associations that came to their mind when reflecting on the concept. Across focus groups, several GPs agreed that they experienced the concept as broad and inclusive, and that the existential dimension was interacting with other illness dimensions as explained by one of the GPs in the following excerpt:

Man 1: I don't think that you can separate it from all the rest. I have a hard time seeing that it's not linked together somehow because the different parts, they weigh differently from patient to patient. There is, for example, always something psychological involved, also in the existential. (Group 2).

A shared opinion among the GPs was that the meaning of the existential could differ from person to

person, and that it was to be understood as “something universally human” (Group 1, woman 3). Only a minority of GPs considered “the spiritual” or “the religious” to be part of this universality indicating in continuation hereof that they were not “very” or “particularly” religious or spiritual themselves, and that spirituality and religion were, therefore, not immediate associations coming to their minds.

Several GPs agreed that, in the forefront of their understandings, were broad themes related to present and future being and identity, relationships with other people and connectedness to a specific society and context. In Group 3, the GPs related why-questions about one’s being and belonging to the existential dimension as exemplified in the following quote:

Woman 2: I think it’s something about “to be”. I mean, to me, it’s something about reflecting about who you are, and the context you are in, the society and maybe, ehm, there are probably many people thinking: Why am I here and not in a different place and ... yea, basic things related to “being”. (Group 3).

In addition to reflections and interpretations about one’s being and belonging, the existential dimension was also understood to involve assessments of a past lived life, personal values, relationships, and future priorities as exemplified in Group 7:

Man 2: Well, it’s something about relating to existence, relating to the life you have, relating to one’s fellow beings, to your family, to the future and to the past, what you have actually been doing in life, is that something that you can build on and, ehm ... in the relationship that you are in, how is the existential relationship ...

As reflected above, several GPs stressed that the existential dimension was a concept pertaining to life in general. One of the ultimate conditions of life, death or finitude, was only mentioned once when asking the GPs about their general understanding, but played a central role when asking them to apply the concept to their practice as will be shown in the next section.

Circumstances under which the existential dimension is addressed in the GP–patient encounter

Across groups, many GPs agreed that the existential dimension primarily entered the GP–patient encounter in circumstances of life-threatening illness when patients faced an increased risk and fear of dying:

Woman 1: Well, the circumstance under which we are mostly concerned with the existential dimension is when we encounter a life-threatening disease,

ehm ... in particular, if there is an increased risk of them dying from it, then it starts to take up much time, but I don’t think that it happens very often. (Group 2)

Recurring themes that were reported to take up much time in connection with palliative or terminal illness stages were related to communication, e.g. with family members about a bad prognosis, to hopes and wishes for the remaining time, to fear of death and of separation from loved ones and to concerns about surviving relatives. However, the majority of GPs agreed that, since seriously ill patients only constituted a small part of the patient population, the existential dimension did not take up much time in daily clinical practice. In one of the groups, this was exemplified as follows:

Man 1: It doesn’t take up so much time since not many patients are really ill, but for the few patients who really are, it’s not a problem. I mean, I’m always busy, but I easily find the time for that, also because I think that it’s so important so it doesn’t matter if it takes up another half an hour every second week. It’s not that which takes up time.

Man 2: No, we don’t have that many very ill patients. I agree with you in that.

Woman 1: It’s not one of the things that take up most time in our everyday life. I wouldn’t say that either, no ... (Group 7)

As indicated by Man 1 above – and as discussed among several of the GPs in the other groups – talking about issues related to the existential dimension was considered specifically relevant in connection with life-threatening diagnoses. Several GPs mentioned that, during treatment, their patients had been “handed over” to a hospital setting which is why their supporting role was “put on hold” until post-treatment during which they would be involved anew in connection with rehabilitation, but first and foremost in connection with palliative or terminal care.

Other circumstances under which the existential dimension was deemed appropriate and relevant to integrate were patients’ life crises, in which stress and depression would be dominating, and unexplainable or diffuse patient symptoms. In the following excerpt, one of the GPs describes how an exploration of the existential dimension becomes clinically interesting and relevant when the other dimensions and practice fields have been exhausted:

Man 1: There is this psychological sphere, in which we can work with some things, and some of us are competent in some matters within that sphere, and we work with it every day. Then there is plenty within the physical sphere, and then we have something existential that fits into the holes and that is weaved into the other spheres, so it’s kind of, it’s there all the

time in the patient, consciously or unconsciously, and it's not being addressed very often, but one senses that it's there anyway, and then there are times when you sense that you have really been working exhaustingly within our normal work spheres, and then it starts to become clear to you that if you wish to move on, and if you would like to help yourself and the patient, then this is something that might be of interest to you. (Group 1).

The existential dimension is described above as being "present all the time in the patient consciously or unconsciously", although rarely addressed in the GP-patient encounter. Discussing the reasons underlying this lacking articulation of the existential dimension, the GPs agreed that several barriers could be mentioned, such as patients' shyness and the GPs' fear of causing discomfort in the patient or concerns about invasion of patients' privacy. According to some GPs, overcoming these communication barriers was crucial in getting to understand the patient better. One GP explained it as follows: sometimes there is just no way around the existential dimension because, when people have physical symptoms, it is not until we start talking with them about their life that we realize why they have stomachaches, so sometimes we just can't cheat ourselves into avoiding it. (Group 7, Man 1).

How the existential dimension is addressed in the GP-patient encounter

When asking the GPs to describe how they would normally address the existential dimension in their clinical work – if at all – they answered that they did not have any systematic or standardized practice. Many GPs noticed that the existential dimension was exempted systematizations and standardizations. Reflecting on this, several GPs explained that they considered issues related to the existential dimension as delicate, private and personal to a degree "that no size could possibly fit all patients". They described how they used their intuition and "gut feeling" in finding out if and how their patients wanted to talk with them about existential problems and concerns:

Man 2: I use to feel my way into what it is that the patient wants to talk more about. Would it be something to talk further about? But I am not the one to primarily raise the subject, but, I mean, it's about feeling one's way into the particular conversation and into what the further course should be like. Would it be something that the patient wishes to talk more about, or, yea...

Man 3: One can't just use the survey style, one is obliged to pay regard to one's... yea, use one's gut feeling... (Group 3).

This intuitive practice was by some described as "an art of medicine" that could not be taught, but grew out of years of practice and continuing GP-patient relationships. To a few other and younger GPs, being left to a "self-made" practice was described as challenging and difficult:

Man 2: I think that with depression, cognitive therapy, anxiety and cognitive therapy, we have kind of put it into a system and learned something. I mean, we know what we are supposed to say and how to work with it, but this, it's kind of self-made, at least to me, it's like, what I feel for, it's like, ah, we'll try this out and that's why it is so difficult. (Group 7).

Most GPs were of the opinion that communication about issues related to the existential dimension happened as an integral part of the ordinary GP-patient communication flow, often facilitated by inviting patients to share their life narratives or to review their lives:

Man 3: I'm not thinking: "Now Madame Jensen is coming, now we are going to have an existential conversation, now I am going to have some kind of life conversation, now I better rise to another level and speak from up there." That's not how we are thinking. I mean, it shouldn't be. It's completely earthly things, they give us their story, sometimes they are frustrated, sometimes they are sad.

Woman 2: Yea, and then you sit down and pray with them (laughing)!

Man 3: We don't do that. I mean, it's completely down-to-earth. (Group 7)

As indicated above, and by several other GPs, addressing existential issues only rarely involved a reference to something religious or spiritual. Another GP expressed it as follows: "I don't think that there are many of us who start talking about spirit and God and things like that with our patients" (Group 1, Woman 1). When asking the GPs how they would address spiritual or religious issues in the encounter with religious or spiritual patients, several GPs explained that they lacked a specialist's competencies in that respect. If they were to discuss spiritual or religious issues with their patients, they would feel like approaching "unknown territory" or walking on "thin ice". While a minority of GPs mentioned that they had made several referrals to the chaplain and considered him/her a "specialist" of good help to primarily their terminal patients, a majority of GPs reported patient referral to the chaplain as infrequent. Several reasons were mentioned for this lacking practice, such as having experienced that patients would rather take care of contacting the religious expert themselves, not knowing the pastor in the area, being afraid of patients'

reactions, finding it difficult to choose the right moment of referral and experiencing religious or spiritual orientations as unfamiliar. When asking the GPs about their experiences with referring their patients to a psychologist, they all agreed that they felt much more confident with suggesting a psychologist to their patients than a chaplain. One of the GPs explained it as follows:

Man 2: It's so easy to have them referred to a psychologist because, in one way or another, they have the right to, when they are struck by a life-threatening disease. I mean, they have the right to receive subsidies, right, yea, please understand me correctly, right, they fulfill the conditions, so they receive subsidies... I think it's more easy than making the chaplain enter the scene. (Group 7).

Many GPs reported addressing death and afterlife imaginations with their terminal patients emphasizing these conversations as existential, but not as being particularly spiritual or religious. These talks were perceived as important, valuable and part of the GP's professional obligation. Several GPs mentioned that death and dying was experienced as a taboo to many of their patients, but that the home environment (visiting patients in their homes) and talking about practical matters (e.g. funeral planning, the last will, etc.) served as facilitators for communication about death.

Discussion

Principal findings and relation to other studies

Results of this study show that the existential dimension was understood to be inseparable from and interconnected with other life dimensions, e.g. the physical and the psychological. A holistic conception of health and illness thus seemed to be prevalent among the GPs. This result reflects the specific ambition of general practice to provide whole-person care and a more general attempt to view health, illness, and suffering as an interconnection between multiple dimensions. Such understandings are put forward in the biopsychosocial-spiritual models of health and illness as also in Cicely Saunders' idea of "total pain".[15]

Given that an increasing number of publications within research and clinical guidance in general practice have focused on the concept of "spirituality" and on how GPs provide "spiritual care",[5,16–18] one of the interesting questions raised in this study was whether Danish GPs understand the existential dimension as involving relationships to the concepts of spirituality or religion/religiosity. Findings showed that, for

the majority of GPs, the reflections about the existential dimension concerned secular-existential issues such as assessments of one's life, relationships, and future being. They were without any explicit reference to a spiritual or religious realm. Our assumption that GPs within a secular, Northern European setting would primarily describe the existential dimension by referring to a secular existential framework has not surprisingly proven to be accurate and is furthermore compatible with GPs' reported spiritual and religious self-unawareness. These findings contrast with results from studies conducted within a general practice setting in America – a country said to be dominantly religious – showing that a large percentage report strong religious or spiritual belief and frequent spiritual or religious practice.[19,20]

The understandings of the existential dimension in this study can, therefore, be said to reflect a secular society in which religious and spiritual values and beliefs have gradually been replaced by secular existential meaning making. According to some sociologists of religion, this development in modern secular societies is a consequence of modernity's rationalistic, naturalistic, and individualistic currents. They have disengaged existential concepts such as meaning, life and death, freedom and identity, from religious meaning systems making it difficult to talk about and relate to religious and/or spiritual aspects for the majority of people.[21]

The opinion of some GPs, that communication about death and dying should not necessarily be associated with a spiritual or religious discourse, can be seen as compatible with this secular ideology that either devalues religious and spiritual perspectives or demotes them to the private sphere. However, the increase in research attention of the past decades on the associations between spiritual/religious faith and health has shown that, although traditional religion has been declining, individualistic spiritual/religious beliefs and practices are perceived as helpful in finding meaning and coping with health-related crises.[22–25]

The finding that the majority of the GPs associated an integration of the existential dimension with life-threatening illness and death does not seem to be in accordance with their understandings of the existential dimension as primarily involving broad, existential life conditions. The central role of general practice in palliative care and the recent guidelines provided for palliation in general practice in Denmark are likely to have influenced the GPs' strong association between the existential dimension and life-threatening illness, death, and dying.[26,27] The encounter with medically

unexplained or diffuse symptoms was also mentioned as motivating a consideration of the possible influence of existential issues on physical symptoms. Given the large evidence about mind–body interactions,[28] considering the existential dimension a last resort calls for a deeper investigation of the many barriers that hinder GPs in showing a more proactive attitude towards addressing the existential dimension in patient care. In several studies, time constraints, expectations of GPs' role and function as well as lack of education have been reported as GP-perceived barriers to the integration of the existential dimension in the GP–patient encounter.[29,30] These organizational and cultural structures, to which these studies refer, seem to have resulted in an imbalanced practice in which many GPs have learned to pay too much attention to some dimensions and not enough to others.

Findings have furthermore shown that GPs primarily rely on their so-called “gut feeling” in addressing the existential dimension in the encounter with the patient. Although a GP's “gut feeling” has been found to provide a valuable pathway to understanding a patient's existential situation and possible stigmatized emotions,[31] it should be questioned to which extent the GP's “gut feeling” is governed by contextual and subjective biases and preconceptions. Could this “gut feeling” ultimately hinder the provision of the “whole-person” care that the patient is in need of?

These critical considerations also pertain to the findings showing that a majority of the GPs reported reluctance or hesitancy towards addressing spiritual or religious issues in the encounter with the patients, many of them shying away from referring their patients to a chaplain. Seen in the broader socio-cultural perspective referred to above, these findings are hardly surprising. When spirituality and religiosity is not part of our horizon, the attention we deem appropriate to pay to these issues is likely to be governed by our own understanding of the world. Thus, studies have shown that sharing patients' spiritual and religious orientations or being spiritually or religiously self-aware constitute facilitating factors in physician–patient communication about existential, spiritual and religious issues.[17,32]

Although the existential dimension has been highlighted as an important part of the care provided by GPs, and a majority of the GPs of this study affirmed its clinical importance in its secular existential form, it must be concluded on the basis of the findings that issues related to this dimension are only brought into focus in the GP–patient encounter in implicit and non-formalized ways.

Implications of the study

Incorporating the existential dimension into general practice to a greater explicit degree implies taking cultural barriers into account and approaching a much wider spectrum of the dimensions influencing health and the healing process. This, in turn, demands much more than attempting to enhance communication skills and techniques, although these are also crucial for the GP–patient relationship. Integrating the existential dimension into general practice demands openness towards patients' meaning making (e.g. as expressed by patients through life narratives), paying attention to, and addressing aspects of patient care that seem culturally and personally awkward, or that have been delegated to the private and personal sphere. In other words, it requires openness towards changing the dominating culture in healthcare and in general practice.

One first step towards advancing a culture change in general practice might be to offer opportunities for professional development (e.g. courses or seminars) where ideas, challenges, and competencies can be shared among GPs and where focus is given on enhancing a different kind of explicit attention to and sensibility towards the patient's multidimensional life world. A second step would be to introduce the relevance of existential issues as a part of the medical curriculum in order to foster a biopsychosocial-existential culture in medical students. Such educational opportunities might not least provide a necessary supplement to the GPs' “gut feeling”.

Strengths and weaknesses

This study is, to the best of our knowledge, the first in Europe to specifically focus on how GPs understand the existential dimension, and on when and how GPs know to address it with patients in their clinical practice. A strength of this study was the multidisciplinary author group representing the humanities as well as the social and the medical sciences hereby eliciting rich and manifold views and discussions on the design of the study as well as on the analysis and interpretation of the data.

Whereas it is beyond the methodological scope of this study to claim empirical generalizability, the research findings have applicability to other GPs, physicians and health professionals from similar cultural and organizational contexts. It could have added validity and depth to the study if additional individual interviews with the participating GPs had been conducted subsequently making it possible to deepen

some of the themes generated in the groups on an individual basis. A comparison of the data generated from individual interviews with the group data could furthermore draw attention to possible weaknesses of the focus group method such as lacking confidence among the GPs or lacking courage to talk about tabooed subjects among other GP colleagues.

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